5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Kansas Medical Assistance Program shall make a reimbursement adjustment for disproportionate share hospitals which are either located in the State of Kansas or located outside of the State of Kansas but operates a hospital that is located within the State of Kansas. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under criteria contained in 6.1000 below. The calculated reimbursement adjustment will be made in quarterly installments to DSH eligible hospitals.

Hospitals to be eligible under 6.1000 must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where non-emergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. Please see section 6.5000 for additional instructions.

All references in the Disproportionate Share sections to Medicaid/MediKan payments and days refer to both fee for service and managed care.

6.1000 Eligibility for DSH Payment

Eligibility for Disproportionate Share Hospital payments shall be determined in accordance with 42 U.S.C. § 1396r-4(b), which deems hospitals to be disproportionate if:

(A) the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State; or

(B) the hospital's low-income utilization rate exceeds 25 percent.

(C) For purposes of paragraph (A), the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period (regardless of whether such patients receive medical assistance on a fee-for-services basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

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6.1000 Eligibility for DSH Payment (continued)

(D) Hospitals meeting the federally defined low-income utilization rate, defined at 42 U.S.C. 1396r-4(b)(1)(B), will be deemed as disproportionate share hospitals and will be eligible for DSH. For purposes of paragraph (B), the term "low-income utilization rate" means, for a hospital, the sum of –

(1) the fraction (expressed as a percentage) –
   a. the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and
   b. the denominator of which is the total amount of net inpatient revenues of the hospital for patient services in the period; and

(2) a fraction (expressed as a percentage) –
   a. the numerator of which is the total amount of the hospital's charge for inpatient and outpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in (1) a. in the period reasonably attributable to inpatient hospital services, and
   b. the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the period.

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6.2000 Limitation on DSH Payments

A. Limitation on Total DSH Funds Allocated
The allocation of DSH funds is structured so as not to exceed the allotment determined by CMS in accordance with section 1923(f)(3) of the Social Security Act. As the DSH payment methodology described in subsequent sections allocates only available DSH funding, in no case shall allocated DSH funds exceed the federal allotment.

B. All Hospitals are limited to no more than their Uncompensated Care Costs (UCC). UCC is the uncompensated cost of care to the uninsured and the uncompensated cost of care to Medicaid participants. The data to be used in the calculating of each hospitals UCC will be obtained from several sources including a provider survey, Medicaid paid claims data, and the provider's Medicare cost report. The period of the data to be utilized will coincide with the period of the Medicare cost report, filed with Medicare, for each hospital that is available no later than four months prior to the start of the state fiscal year for which payments are being made. This limitation is computed by Medicaid below.

B1. UCC Uninsured Inpatients - For purposes of the DSH calculation the uninsured are defined as those individuals who lack third party coverage for eligible services received. Hospitals are required to submit on their annual DSH survey the amount of uninsured charges and payments attributable to inpatient hospital services. These uninsured charges will be multiplied by the hospital's inpatient cost to charge ratio as calculated from their Medicare cost report to arrive at total inpatient uninsured costs. The total inpatient payments received from the uninsured will be subtracted from the costs to arrive at the uncompensated uninsured inpatient costs. The report uninsured charges and payments should exclude non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facility (NF), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), as well as physician charges.

B2. UCC Uninsured Outpatients - For purposes of the DSH calculation the uninsured are defined as those individuals who lack third party coverage for eligible services received. Hospitals are required to submit on their annual DSH survey the amount of uninsured charges and payments attributable to outpatient hospital services. These uninsured charges will be multiplied by the hospital's outpatient (ancillary) cost to charge ratio as calculated from their Medicare cost report to arrive at total outpatient uninsured costs. The total outpatient payments received from the uninsured will be subtracted from the costs to arrive at the uncompensated uninsured outpatient costs. The report uninsured charges and payments should exclude non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facility (NF), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), as well as physician charges.

B3. Kansas Medicaid Inpatient Days in last available fiscal year of hospital. The Kansas Medicaid Inpatient Days will be obtained from paid claims data for the period of the hospital's cost report used in the DSH calculation as identified in Section 6.2000 B.

B4. All Medicaid Inpatient Days in last available fiscal year of hospital. All Medicaid inpatient days are the total of Kansas inpatient Medicaid days obtained from the paid claims summary, and the hospitals out-of-state Medicaid inpatient days obtained from the provider survey. The service period for accumulating these days will coincide with the cost reporting period identified in 6.2000 B.

B5. Kansas portion of Medicaid inpatient days (B3 / B4).

B6. Kansas portion of Uninsured Inpatient Uncompensated Cost (B1 x B5).

B7. Kansas portion of Uninsured Outpatient Uncompensated Cost (B2 x B5).

B8. UCC Kansas Medicaid Inpatients - The UCC related to Kansas Medicaid inpatients is calculated by multiplying the Kansas Medicaid inpatient charges as obtained from the paid claims summary, times the inpatient cost to charge ratio as determined from the hospital's cost report to arrive at calculated Medicaid inpatient costs. Total Kansas inpatient Medicaid payments, including any supplemental or enhanced payments, are then subtracted from the calculated Medicaid inpatient costs to arrive at the UCC for Kansas inpatient Medicaid services. If the result of this calculation is a negative, or gain, this amount is used to reduce the hospital's overall UCC.

B9. UCC Kansas Medicaid Outpatients - The UCC related to Kansas Medicaid outpatients is calculated by multiplying the Kansas Medicaid outpatient charges as obtained from the paid claims summary, times the outpatient (ancillary) cost to charge ratio as determined from the hospital's cost report to arrive at calculated Medicaid outpatient costs. Total Kansas Outpatient Medicaid payments, including any supplemental or enhanced payments, are then subtracted from the calculated Medicaid outpatient costs to arrive at the UCC for Kansas outpatient Medicaid services. If the result of this calculation is a negative, or gain, this amount is used to reduce the hospital's overall UCC.

B10. Total Facility Specific DSH Limitation (B6 + B7 + B8 + B9).

(Reserved for future use)

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An example of both the eligibility and payment adjustment computations are attached.

6.3000 Allocation of DSH Funds

Effective for DSH calculations beginning July 1, 2007, total available DSH funds shall be distributed among DSH eligible facilities as defined in 6.10000 above based upon each facility's burden of uncompensated care costs relative to their peers. The calculation of the total available DSH funds and the DSH funding pools is contained at Section 6.3000 B. In addition, pools of DSH funding will be established for like groups of facilities to establish limitations on the available funding for each pool.

A. Available DSH funds to the following types of hospitals will be limited as follows:
   a. Out-of-State hospitals – DSH eligible out-of-state hospitals will share in a pool of DSH funds. The pool of DSH funds available for DSH eligible out-of-state hospitals will be calculated each year and limited to no more than 10% of the Federal DSH allotment for the State of Kansas. The amount of the out-of-state DSH pool is displayed in the table at 6.3000 B.
   b. State-owned or operated teaching facilities – DSH eligible hospitals that are state-owned or operated and provide graduate medical education programs will share in a pool of DSH funds. The pool of DSH funds available for DSH eligible state-owned or operated teaching hospitals will be calculated each year, and limited to no more than .25% of the Federal DSH allotment for the State of Kansas. The amount of the out-of-state DSH pool is displayed in the table at 6.3000 B.
   c. In-state hospitals eligible for DSH payments that are not classified as institutes for mental disease (IMDs) and were not included in either of the pools of Section 6.3000 A. a. or b. above will be distributed the remaining DSH funds for non-IMD hospitals. The remaining DSH funds for distribution to this pool will consist of the Federal DSH allotment for the state of Kansas for non-IMD hospitals less the DSH payments calculated for DSH eligible hospitals included in Sections 6.3000 A. a. and 6.3000 A. b.

B. Pools will be established in the following order:
   1. IMD Pool
   2. Out-of-State Pool
   3. State-Owned/Operated Teaching Hospital Pool
   4. Other-in-state DSH Eligible Hospital Pool

   The following table illustrates the total DSH funds available for federal fiscal year 2010 and the amounts allocated to each pool.

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	Federal FY 2012
Total Federal DSH Allotment	42,243,450
FMAP	56.91%
Total DSH Funds Available	74,228,519
Federal Limit on DSH for IMD's	24,495,411
DSH Funds for Non-IMD Hospitals	49,733,108
Pools of Non-IMD DSH for Federal FY 2012	
Out of State Hospitals	4,973,311
State-Owned/Operated Teaching Hospitals	124,333
Other in-state DSH Eligible Hospitals	44,635,464
Total	49,733,108

C. The initial allocation of DSH funds will be made to hospitals that lose eligibility in any given year, that were eligible for DSH funds in each of the preceding two years. These hospitals will be eligible to receive 50% of their previous year's payment in the year they initially lose eligibility. Hospitals eligible under this provision will receive the lesser of 50% of their previous year's payment, or their UCC as defined in 6.2000 B. In addition, to be eligible for any payment these hospitals must continue to meet the minimum eligibility criteria of 1% Medicaid utilization and the Federal obstetrician requirement.

D. The allocation of DSH funds among eligible hospitals that are not IMD will distribute DSH funds proportionally to hospitals in each pool based upon each hospitals relative burden of uncompensated care costs to total facility expenses, as follows:

a. Hospital Burden: The hospital burden of each DSH eligible hospital is calculated to determine the percentage of the hospital's business that is related to providing uncompensated care. This burden is calculated by dividing the hospital's UCC as defined in Section 6.2000 B., by the hospital's total cost. For purposes of the hospital burden calculation, the total hospital costs will be determined from the

6.3000 Allocation of DSH Funds (continued)

hospital's cost report as identified in Section 6.2000 B. The total hospital cost will be the total cost from Worksheet B Part I of the cost report less any costs associated with non-hospital services such as: Skilled Nursing Facilities (SNF), Nursing Facility (NF), Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC). The hospital burden will be calculated as follows:

i. F = Facility's Burden (UCC / Total Costs)
The term "Total Costs" as used in this section is referring to the total hospital related costs, excluding any SNF, NF, clinics, etc.
ii. F^L = Lowest % Burden of DSH Eligible Facilities
iii. F^H = The Average of the Three Highest % Burdens of DSH Eligible Hospitals

b. Range of DSH Proportion:
i. P = Percentage Rank = $(F - F^L)/(F^H - F^L)$
ii. P^L = Proportion of Rank-Adjusted DSH Limit Covered – P^L represents the proportion of the percentage rank-adjusted UCC cost that will be covered for the hospital. The proportion P^L is the same for each hospital and cannot exceed 100%. The Proportion of Rank-Adjusted DSH Limit Covered is one of the final elements calculated in the DSH methodology and is incrementally raised or lowered until the entire Federal DSH allotment for the State of Kansas has been allocated.
iii. P^H = Maximum Percentage Rank (P^H is fixed at 100% to ensure that each facility's UCC is not exceeded).
iv. D = Facility's UCC

c. Formula for DSH Payment:
i. If $P > P^H$ then $P^L \times (P^H \times D)$ else $P^L \times (P \times D)$

E. Eligible hospitals that are defined as Institutes for Mental Disease (IMD) will receive an allocation of DSH funds from the allotted IMD pool as defined in 6.3000 B above. The allocation to DSH eligible IMD hospitals will be calculated by dividing each eligible IMD hospital's UCC by the total UCC for all DSH eligible IMD hospitals. The percentage calculated will then be multiplied times the total allotment for IMD hospitals as defined in section 6.3000 B above. Each IMD hospital will receive the lower of the calculated amount or their UCC as defined in 6.2000 B.

F. Reallocation of DSH Funds: Upon completion of the certified DSH audit for the audited period, the State will re-run the entire DSH distribution formula for the audited period as outlined in Section 6.3000.D, using the corrected levels of uncompensated care (for the audited period). The DSH allocation for the audited period will be used for the re-run and redistribution. The redistribution will result in a neutral transaction for State and Federal funds. The transaction will be identified using a reason code in MMIS called "Prior Period DSH Adjustment".

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6.3000 Allocation of DSH Funds (continued)

The redistribution will be performed if the following thresholds are met. The reopening threshold is a change of 8% (positive or negative) of the original DSH amount for any (single) hospital, or if an adjustment to any single hospital is greater or equal to $30,000 (positive or negative).

Interim Audit Adjustment: Upon completion of the audit review of the survey data period utilized for the initial (original) DSH distribution, the state may update the original (interim) DSH distribution to audited amounts if it is believed that the adjustment will materially change the original distribution. The initial DSH distribution is based on survey data described at 6.3000.D. This adjustment would effectively be an interim adjustment to-be-settled. The final DSH distribution is based on the certified DSH audit results, which utilizes provider data that is contemporary with the audited DSH period. The materiality threshold utilized for this interim adjustment is as follows is the same as noted for the final redistribution

G. Provider Payment Adjustment: If a provider Medicaid non-DSH payment (claims, supplemental, etc) is adjusted in a subsequent period and the amount previously was included in the calculation of the provider's uncompensated care, the claims payment adjustment impact on uncompensated care for DSH will be reflected in the period of adjustment (repayment). As such, the transaction will be treated prospectively and prior year DSH payments will not be adjusted.

6.4000 Transition Provisions

The following transition provisions are provided to allow hospitals that experience a significant change in their allocated DSH funds due to the new methodology, a gradual change in their DSH reimbursement. The base period for transition calculations will be the DSH payments that were calculated for fiscal year 2007. The transition provisions vary among the critical access hospitals (CAH), and the non-CAH. The transition provisions will be applied to the computed DSH payments in the following order:

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6.4000 Transition Provisions (continued)

A. Transition for CAH will be accomplished as follows:
   a. CAH that experience an increase in their allocated DSH funds will receive 100% of that increase.
   b. CAH that experience a decrease in their allocated DSH funds will receive the lesser of their 2007 payment or their facility specific DSH limit so long as they continue to meet the minimum eligibility criteria of 1% Medicaid utilization and the Federal obstetrician requirement.

B. Transition for non-CAH will be accomplished over a three year transition period as follows:
   a. Non-CAH that experience a decrease in their allocated DSH funds will receive a reduction of 1/3 of the difference between the 2007 DSH funds and current allocation in SFY 2008, a reduction of 2/3 of the difference between 2007 DSH funds and the current allocation in SFY 2009, and will receive the calculated allocation for 2010. The hospital will receive the lesser of the transition amount calculated or the hospital's UCC.
   b. Non-CAH that experience an increase in their calculated DSH reimbursement will receive a percentage, determined annually by Medicaid, of their calculated amount. This percentage will be calculated after the other DSH calculations and transition provisions have been calculated. The percentage will start at 100% and be incrementally lowered until the result of the DSH allocation is equal to the Federal DSH allotment for the state of Kansas.

6.5000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000, a hospital may request in writing a review of the determination within 15 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

A. Appeals rights are limited to errors in the DSH formula and errors that may result in material overstatement of DSH based on data submitted in the provider's DSH form.